MEDICAL REQUEST FOR HOME INSTRUCTION (To be completed by the Student's Treating Physician and/or Psychiatrist) DOB Student's name (Last, First) Is under my care for the following (Diagnosis): Home instruction provides 5 hours of instruction per week for Grades K-6 and 10 hours per week for Grades 7-12. Please provide detailed and specific information defining the limitations that the student has in order to inform the Department of Education about the necessity of Home Instruction services. Attach additional documentation as needed. I hereby request that this child receive Home Instruction because of the above limitations due to this/these diagnosis/es which preclude this child's attending school. ☐ my professional opinion This request is based on: □ parental request other I request that Home Instruction be provided for weeks (no less than 4 weeks) Practitioner's Name (print) Degree Practitioner's Original Signature Date of Signature License **CONTACT INFORMATION** Extension Telephone # Fmail Cell phone # Pager# Times/hours I can be reached: Mon___ Tues Wed Thurs _Friday _ PRACTITIONER'S STAMP Attending Physician or Fellow other Psychiatrist ■ Nurse Practitioner Oral Surgeon Podiatrist NOTE: Residents are not allowed to complete this form. All referrals should be sent to the appropriate borough office Queens Brooklyn ☐ Manhattan ☐ Staten Island ☐ Bronx 470 Jackson Avenue 360 36th Street 360 36th Street 250 West Houston Street 142-10 Linden Boulevard Room 112 Brooklyn, NY 11232 Room 212 Room 228 Room 301 New York, NY 10014 Bronx, NY 10455 Room 302 Jamaica, NY 11436 Brooklyn, NY 11232 (P) 718-742-0972 (P) (718-369-5550 (P)646-486-3557 (P) 718-558-2040 Brooklyn District: 20 (F) 718-742-1792 (F) 718-299-2304 (F)718-472-6113 (F) 718-529-0292 Room 314 & 316 Room 318 & 319 (P) (718) 499 -2794 (P) 718-369-5523 (F) (718) 499 - 4009 (F) 718-369-5524